General Assembly

Raised Bill No. 7110

January Session, 2007

LCO No. **4166**

____HB07110PRIHS_030907___

Referred to Committee on Program Review and Investigations

Introduced by:
(PRI)

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE FUNDING OF HOSPITAL CARE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-239 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The rate to be paid by the state to hospitals receiving appropriations granted by the General Assembly and to freestanding chronic disease hospitals, providing services to persons aided or cared for by the state for routine services furnished to state patients, shall be based upon reasonable cost to such hospital, or the charge to the general public for ward services or the lowest charge for semiprivate services if the hospital has no ward facilities, imposed by such hospital, whichever is lowest, except to the extent, if any, that the commissioner determines that a greater amount is appropriate in the case of hospitals serving a disproportionate share of indigent patients. Such rate shall be promulgated annually by the Commissioner of Social Services. Nothing contained in this section shall authorize a payment by the state for such services to any such hospital in excess of

the charges made by such hospital for comparable services to the general public. Notwithstanding the provisions of this section, for the rate period beginning July 1, 2000, rates paid to freestanding chronic disease hospitals and freestanding psychiatric hospitals shall be increased by three per cent. For the rate period beginning July 1, 2001, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two and one-half per cent more than the rate it received in the prior fiscal year and such rate shall remain effective until December 31, 2002. Effective January 1, 2003, a freestanding chronic disease hospital or freestanding psychiatric hospital shall receive a rate that is two per cent more than the rate it received in the prior fiscal year. Notwithstanding the provisions of this subsection, for the period commencing July 1, 2001, and ending June 30, 2003, the commissioner may pay an additional total of no more than three hundred thousand dollars annually for services provided to long-term ventilator patients. For purposes of this subsection, "long-term ventilator patient" means any patient at a freestanding chronic disease hospital on a ventilator for a total of sixty days or more in any consecutive twelve-month period. Effective July 1, 2004, each freestanding chronic disease hospital shall receive a rate that is two per cent more than the rate it received in the prior fiscal year.

(b) Effective October 1, 1991, the rate to be paid by the state for the cost of special services rendered by such hospitals shall be established annually by the commissioner for each such hospital based on the reasonable cost to each hospital of such services furnished to state patients. Nothing contained herein shall authorize a payment by the state for such services to any such hospital in excess of the charges made by such hospital for comparable services to the general public.

(c) The term "reasonable cost" as used in this section means the cost of care furnished such patients by an efficient and economically operated facility, computed in accordance with accepted principles of hospital cost reimbursement. The commissioner may adjust the rate of payment established under the provisions of this section for the year

during which services are furnished to reflect fluctuations in hospital costs. Such adjustment may be made prospectively to cover anticipated fluctuations or may be made retroactive to any date subsequent to the date of the initial rate determination for such year or in such other manner as may be determined by the commissioner. In determining "reasonable cost" the commissioner may give due consideration to allowances for fully or partially unpaid bills, reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators, requirements for working capital and cost of development of new services, including additions to and replacement of facilities and equipment. The commissioner shall not give consideration to amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit the commissioner from considering amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations.

(d) The state shall also pay to such hospitals for each outpatient clinic and emergency room visit a reasonable rate to be established annually by the commissioner for each hospital, such rate to be determined by the reasonable cost of such services. **[**The emergency room visit rates in effect June 30, 1991, shall remain in effect through June 30, 1993, except those which would have been decreased effective July 1, 1991, or July 1, 1992, shall be decreased.**]** Nothing contained herein shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public. **[**For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios in effect June 30, 1991, shall be reduced effective July 1, 1991, by the most recent annual increase in the consumer price index for medical care. For those

outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios computed to be effective July 1, 1994, shall be reduced by the most recent annual increase in the consumer price index for medical care. The emergency room visit rates in effect June 30, 1994, shall remain in effect through December 31, 1994. The Commissioner of Social Services shall establish a fee schedule for outpatient hospital services to be effective on and after January 1, 1995. Except with respect to the rate periods beginning July 1, 1999, and July 1, 2000, such fee schedule shall be adjusted annually beginning July 1, 1996, to reflect necessary increases in the cost of services. Notwithstanding the provisions of this subsection, the fee schedule for the rate period beginning July 1, 2000, shall be increased by ten and one-half per cent, effective June 1, 2001. Notwithstanding the provisions of this subsection, outpatient rates in effect as of June 30, 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006, subject to available appropriations, the commissioner shall increase outpatient service fees for services that may include clinic, emergency room, magnetic resonance imaging, and computerized axial tomography.**]** Not later than October 1, 2006, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies, identifying **[**such**]** fee increases that became effective on July 1, 2006, and the associated cost increase estimates. Effective October 1, 2007, and annually thereafter, the Commissioner of Social Services shall adjust outpatient hospital services rates paid on the basis of a fee schedule or on the basis of a ratio of cost to charges by the most recent annual increase in the consumer price index for urban consumers.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing criteria for defining emergency and nonemergency visits to hospital emergency rooms. All nonemergency visits to hospital emergency rooms shall be paid at the hospital's outpatient clinic services rate. Nothing contained in this

subsection or the regulations adopted hereunder shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public.

[(f) On and after October 1, 1984, the state shall pay to an acute care general hospital for the inpatient care of a patient who no longer requires acute care a rate determined by the following schedule: For the first seven days following certification that the patient no longer requires acute care the state shall pay the hospital at a rate of fifty per cent of the hospital's actual cost; for the second seven-day period following certification that the patient no longer requires acute care the state shall pay seventy-five per cent of the hospital's actual cost; for the third seven-day period following certification that the patient no longer requires acute care and for any period of time thereafter, the state shall pay the hospital at a rate of one hundred per cent of the hospital's actual cost. On and after July 1, 1995, no payment shall be made by the state to an acute care general hospital for the inpatient care of a patient who no longer requires acute care and is eligible for Medicare unless the hospital does not obtain reimbursement from Medicare for that stay.

(g) Effective June 1, 2001, the commissioner shall establish inpatient hospital rates in accordance with the method specified in regulations adopted pursuant to this section and applied for the rate period beginning October 1, 2000, except that the commissioner shall update each hospital's target amount per discharge to the actual allowable cost per discharge based upon the 1999 cost report filing multiplied by sixty-two and one-half per cent if such amount is higher than the target amount per discharge for the rate period beginning October 1, 2000, as adjusted for the ten per cent incentive identified in Section 4005 of Public Law 101-508. If a hospital's rate is increased pursuant to this subsection, the hospital shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508. For rate periods beginning October 1, 2001, through September 30, 2006, the

commissioner shall not apply an annual adjustment factor to the target amount per discharge. Effective April 1, 2005, the revised target amount per discharge for each hospital with a target amount per discharge less than three thousand seven hundred fifty dollars shall be three thousand seven hundred fifty dollars. Effective October 1, 2006, subject to available appropriations, the commissioner shall establish an increased target amount per discharge of not less than four thousand dollars for each hospital with a target amount per discharge less than four thousand dollars for the rate period ending September 30, 2006, and the commissioner may apply an annual adjustment factor to the target amount per discharge for hospitals that are not increased as a result of the revised target amount per discharge. Not later than October 1, 2006, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies identifying the increased target amount per discharge and the associated cost increase estimates.**]**

(f) Effective October 1, 2006, subject to available appropriations, the commissioner shall establish an increased target amount per discharge of not less than four thousand dollars for each hospital with a target amount per discharge less than four thousand dollars for the rate period ending September 30, 2006, and the commissioner may apply an annual adjustment factor to the target amount per discharge for hospitals that are not increased as a result of the revised target amount per discharge. Not later than October 1, 2006, the commissioner shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services and appropriations and the budgets of state agencies identifying the increased target amount per discharge and the associated cost increase estimates. Effective October 1, 2007, and for each succeeding hospital fiscal year thereafter, the commissioner shall establish an inpatient hospital Medicaid fee-for-service rate for acute care hospitals. The commissioner shall utilize a

prospective payment system to establish such rate. The base payment rate under the prospective payment system shall be the hospital Medicare base rate as adjusted by the Medicare wage index. The commissioner shall then adjust the base payment rate for each hospital by the following factors: (1) For teaching hospitals with indirect medical education expenses, the base payment rate shall be adjusted to reflect a Medicaid portion of such expenses. The Medicaid portion shall be calculated using the amount of the expense in excess of the Medicare base rate attributable to indirect medical education expenses for each qualifying hospital and multiplying that amount by the ratio of the number of Medicaid and state-administered general assistance inpatient discharges to the total number of discharges for such hospital, and (2) for each hospital the commissioner shall multiply the hospital's Medicare wage adjusted base rate, or, in the case of teaching hospitals, the Medicare wage adjusted base rate as adjusted in accordance with the provisions of subdivision (1) of this subsection by the hospital's most recent Medicaid case mix, as defined in subdivision (10) of section 19a-659. Effective October 1, 2007, the Commissioner of Mental Health and Addiction Services shall also utilize the payment system set forth in this subsection in calculating inpatient hospital rates paid on behalf of state-administered general assistance beneficiaries.

Sec. 2. Section 17b-296 of the general statutes is amended by adding subsection (e) as follows (*Effective July 1, 2007*):

(NEW) (e) When renewing a contract with a managed care organization, the department shall: (1) Require that the managed care organization increase rates paid to providers by the percentage increase, if any, in the per client per month rate charged by the managed care organization; and (2) shall establish the number of emergency room visits allowed per client for nonemergency events and to impose financial penalties on those managed care organizations whose clients exceed limits established by the department. Any moneys received as the result of the financial penalties imposed

pursuant to this subsection shall be used by the department to supplement funding to hospitals experiencing an over use of the emergency room for nonemergency events.

Sec. 3. Section 17b-239a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

[The**]** Subject to the provision of this section, the Department of Social Services may, within available funds, make payments to all short-term general hospitals located in distressed municipalities, as defined in section 32-9p, or with a population greater than seventy thousand. **[**and to all short-term general hospitals located in targeted investment communities with enterprise zones, as defined in section 32-70, with a population greater than one hundred thousand.**]** The payment amount for each hospital shall be determined by the Commissioner of Social Services based upon the ratio that the number of inpatient discharges paid by the state-administered general assistance program and Medicaid on a fee-for-service basis to the hospital for the most recently filed cost report period bears to the total hospital discharges paid by the state-administered general assistance program and Medicaid on a fee-for-service basis for all qualifying hospitals. **[**Notwithstanding the provisions of this section, no**]** No payment shall be made to a facility licensed as a children's hospital.

Sec. 4. (NEW) (*Effective July 1, 2007*) (a) Subject to the provisions of this section, the Department of Social Services shall, within available appropriations, make payments to hospitals that provide a disproportionate share of outpatient services to Medicaid and state-administered general assistance beneficiaries. The Commissioner of Social Services shall determine eligibility standards for the receipt of such payments and the amount of any payment made to a hospital pursuant to this section. No payment shall be made to a facility licensed as a children's hospital.

(b) The commissioner, pursuant to section 17b-10 of the general statutes, may implement policies and procedures to administer the

provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policy shall be valid until the time final regulations are adopted.

Sec. 5. Subsection (b) of section 19a-649 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(b) Each hospital shall **[**annually**]** report **[**, along with data**]** to the office on an annual basis: Data submitted pursuant to subsection (a) of this section, **[**(1)**]** the number of applicants for free and reduced cost services, **[**(2)**]** the number of approved applicants, and **[**(3)**]** the total and average charges and costs of the amount of free and reduced cost care provided. After reviewing all data provided by hospitals to the office pursuant to the requirements of this subsection, the office shall conduct a comparative analysis of such data based on hospital bed size and geographic location and report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies advising on: Each hospital's policy regarding the provision of free and reduced cost services, including the availability of hospital bed funds, the number of applications for free and reduced cost services, the number of granted applications for free and reduced cost services, and the charges and costs incurred to provide such free and reduced cost services.

Sec. 6. Subsection (a) of section 19a-613 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The Office of Health Care Access may employ the most effective and practical means necessary to fulfill the purposes of this chapter, which may include, but need not be limited to:

(1) Collecting aggregate financial data from health care facilities or institutions, as defined in section 19a-630, and patient-level outpatient data from **[**health care**]** such facilities or institutions **[**, as defined in section 19a-630**]** and thereafter analyzing and reporting on such data, in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(2) Establishing a cooperative data collection effort, across public and private sectors, to assure that adequate health care personnel demographics are readily available; and

(3) Performing the duties and functions as enumerated in subsection (b) of this section.

Sec. 7. Subsection (a) of section 19a-644 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) On or before February twenty-eighth annually, for the fiscal year ending on September thirtieth of the immediately preceding year, each short-term acute care general or children's hospital shall report to the office with respect to its operations in such fiscal year, in such form as the office may by regulation require. Such report shall include: (1) Salaries and fringe benefits for the ten highest paid positions; (2) the name of each joint venture, partnership, subsidiary and corporation related to the hospital; **[**and**]** (3) the salaries paid to hospital employees by each such joint venture, partnership, subsidiary and related corporation and by the hospital to the employees of related corporations; (4) the operating expenses per each case mix adjusted discharge and equivalent discharge; and (5) the marketing expenses of such hospitals.

Sec. 8. (NEW) (*Effective July 1, 2007*) Not later than October 1, 2007, and for each hospital fiscal year thereafter, the Office of Health Care Access shall report to the joint standing committees of the General

Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, in accordance with section 11-4a of the general statutes, on the financial status of Connecticut's acute care hospitals for the fiscal year that ended on September thirtieth of the preceding year. Such report shall contain, at a minimum, all information required to be compiled pursuant to subsection (a) of section 19a-644 of the general statutes, as amended by this act.

Sec. 9. (*Effective from passage*) (a) There is established a panel which shall advise the Governor and the General Assembly on matters relating to health care. The panel shall advise on matters that include, but are not limited to, examining health care costs, making private health insurance more affordable and improving access to primary and preventive health care. The panel shall provide legislative recommendations to the Governor and the General Assembly concerning health care reform.

(b) The panel shall consist of the following members:

(1) Ten appointed by the Governor, who shall include a representative from: The Connecticut Hospital Association, the Connecticut Business and Industry Association, the Connecticut State Medical Society, the Connecticut Nurses' Association, the Connecticut Primary Care Association, the Connecticut Association of Health Care Facilities and the Connecticut Association of Health Plans;

(2) One appointed by the speaker of the House of Representatives;

(3) One appointed by the president pro tempore of the Senate;

(4) One appointed by the majority leader of the House of Representatives;

(5) One appointed by the majority leader of the Senate;

(6) One appointed by the minority leader of the House of

Representatives;

(7) One appointed by the minority leader of the Senate;

(8) The Commissioners of the Office of Health Care Access, Social Services, Public Health, Mental Health and Addiction Services, the Insurance Commissioner and the Secretary of the Office of Policy and Management, or their designees; and

(9) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, insurance, commerce, public health, appropriations and the budgets of state agencies and finance, revenue and bonding.

(c) All appointments to the panel shall be made not later than September 1, 2007. Any vacancy shall be filled by the appointing authority.

(d) The chairpersons of the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance shall schedule the first meeting of the panel. At the initial meeting of the panel, the convened membership shall select the chairpersons of the panel, from among the panel's membership. Thereafter, the panel shall meet monthly and more often upon the call of the chairpersons or a majority of its members.

(e) The Joint Committee on Legislative Management shall provide administrative support to the panel.

(f) On or before March 1, 2008, the panel shall report, in accordance with section 11-4a of the general statutes, on its activities to the joint standing committees of the General Assembly having cognizance of matters relating to human services, insurance, commerce, public health, appropriations and the budgets of state agencies and finance, revenue and bonding.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2007*	17b-239
Sec. 2	*July 1, 2007*	17b-296
Sec. 3	*July 1, 2007*	17b-239a
Sec. 4	*July 1, 2007*	New section
Sec. 5	*July 1, 2007*	19a-649(b)
Sec. 6	*July 1, 2007*	19a-613(a)
Sec. 7	*July 1, 2007*	19a-644(a)
Sec. 8	*July 1, 2007*	New section
Sec. 9	*from passage*	New section

PRI *Joint Favorable C/R* HS